STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007231	A. BUILDING: _____ B. WING _____	C 01/30/2024

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S 000	Initial Comments Complaint Investigation 2410743/ IL 169187	S 000		
S9999	Final Observations Statement of Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999		

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meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Requirements were not met evidenced by:

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Based on record review and interview, the facility failed to ensure safety and supervision was provided for a resident in the dining room. This failure resulted in a resident falling in the dining room on 1/23/24 and sustaining a left hip fracture for 1 of 4 residents (R1) reviewed for safety and supervision in the sample of 4.

The findings include:

The Minimum Data Set dated 10/5/23 for R1 showed extensive assistance of one person needed for walking in her room and corridor.

The Monthly Summary for R1 showed she is alert, confused and has a poor memory. R1 needs assistance with ambulation and uses a walker with assistance. R1 has diagnoses including dementia, anxiety, falls, overactive bladder, hyperlipidemia, hypertension, peripheral vascular disease, aortic stenosis, and osteoarthritis.

The Service/Functional Assessment dated 1/5/24 for R1 showed a score of 22 for fall prevention which meant she was at high risk for falls. The ambulation/physical ability section showed R1 needed stand by assistance with the use of a gait belt and 1 person assist as needed. The Cognition section showed R1 had severe cognitive impairment.

The Face Sheet dated 1/10/24 for R1 showed she is 100 years old, ambulates with gait belt, assist of 1, and walker. The goals between staff and the resident that were attached to the face sheet for R1 showed, falls will be minimized and injuries to falls will be as least problematic as possible
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The Care Plan for R1 that was reviewed and revised on 1/10/24 showed R1 is in memory care. She is here because of confusion but will be moving to the health center for additional care. She ambulates with a gait belt and 1 assist with a walker. Difficulty walking at times. Nursing ambulates to/from most areas with gait belt, assistance of one, uses wheelchair as needed. Assess the safety of the environment. The Falls section of the care plan for R1 showed, R1 is at risk for falls due to mobility issues. She uses a walker, a gait belt, and 1 assist. History of fall.

The Nurse's Notes dated 1/23/24 for R1 showed: 6:10 PM - Resident had an unwitnessed fall at this time. Found in the dining room laying in a supine position. When she was asked what happened, the resident stated, "I was finished eating and was heading to my room." Vital signs taken, temperature 98.2, pulse 100, respiratory rate 20, and blood pressure 130/87. Physical assessment performed. Resident found to have a lump on the back of her head, and she complained of left hip pain. Ice applied to head. Notifications made to provider and then to the family. 911 was notified and the resident was transported to the hospital emergency department for treatment. At 11:45 PM this writer called the hospital emergency room for an update. R1 will be admitted for pain control and physical therapy due to the left hip fracture that is stable and will not need surgery.

The Incident/Accident Report dated 1/23/24 for R1 showed she fell when she was getting up from the table and it was an unwitnessed fall.

The facility's Mealtimes dated 1/30/24 showed the supper mealtime for the health center was 5:00 PM.

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On 1/30/24 at 11:59 AM, V7 LPN (Licensed Practical Nurse) stated, R1 was a 1 person assist with a gait belt and walker. She came up from the memory care unit. When R1 initially came up here it was passed in report that R1 would try to self-transfer. We kept R1 in the living room area.

On 1/30/24 at 12:37 PM, V9 RN (Registered Nurse) stated she is an agency nurse, and it was her first shift at the facility. V9 stated it was 6:10 PM when R1 fell. V9 stated, two dietary aides came running out of the dining room to alert me that a resident had fallen. R1 was laying supine on the floor of the dining room and was awake. R1's walker was two feet behind her chair. R1 stated she was trying to go back to her room. R1 probably stood up trying to find her walker. The charge nurse came in. R1 had a bump to the back of her head. We assessed her together. R1 had her hands on her left hip and complained of pain to the hip. V9 stated the charge nurse made the calls and emergency medical services arrived and took over from there. V9 stated there wasn't any staff in the dining room with R1 when she fell. V9 stated staff should have been in the dining room monitoring the residents. V9 stated there were 3 CNAs (Certified Nursing Assistants) and her assigned to that unit. There should have been a CNA in the dining room but at that moment there wasn't. V9 stated the charge nurse said someone should have been in the dining room until all the residents were out of the dining room.

On 1/30/24 at 1:02 PM, V11 CNA stated she was not in the dining room when R1 fell. V11 stated she did not think the other two CNAs, V12 and V13, were in the dining room either. V11 stated the last CNA she saw in the dining room was V12. V11 stated they are supposed to always

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have someone in the dining room, so nobody falls.

On 1/30/24 at 1:10 PM, V12 CNA stated she was not in the dining room when R1 fell. V11 was in the dining room feeding a resident. V12 stated she left the dining room to toilet a resident. V12 stated when she came back into the dining room V10 LPN was in there. V12 stated she did not know R1 had fallen when she came back to the dining room. V12 stated V10 said they were not supposed to leave residents alone in the dining room.

On 1/30/24 at 1:30 PM, V10 LPN stated, I was the charge nurse that night. I walked onto the unit to check on V9 because it was her first time here. Dietary yelled that R1 was on the floor. I went in there and R1 was on her back. R1 was awake and I did a quick assessment. There were other residents in the dining room. There were no CNAs in the dining room when it happened. Dietary had just gone in there and saw R1 on the floor. They should have had someone in the dining room providing supervision and this would not have happened.

On 1/30/24 at 3:10 PM, V13 CNA stated he was working in the health center with V11 CNA and V12 CNA when R1 fell. V13 stated V12 wasn't in the dining room because she was doing patient care. V11 was left in the dining room while he was taking residents out of the dining room. V13 stated he switched units at 6:00 PM - 6:10 PM so he was not there for the fall. V13 stated they should always have one person in the dining room with the residents until everyone is out of the dining room. V13 stated it is important because of people like R1 who can fall and get a hip fracture; so, they can prevent falls.

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S9999	Continued From page 6 On 1/30/24 at 3:41 PM, V14 (Dietary Aide) stated it was between 6:00 PM - 6:30 PM around the time they were supposed to get the dietary carts and her and her co-worker went into the dining room. V14 stated they heard R1 yelling "help me" and they went over to her. R1 was on the floor so she went and got the nurse. V14 stated there was no one in the dining room with the residents when they came up and found R1 on the floor. The facility's Policy & Procedure to Prevent Accidents (5/22/14) showed all staff are to be involved in observing and identifying potential hazards at the facility. (A)	S9999		